STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

The Recovery Project
Petitioner **File No. 21-1777**

v

Auto Club Insurance Association
Respondent

Issued and entered
this 14th day of February 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On November 23, 2021, The Recovery Project (Petitioner) filed with the Department of Insurance and Financial Services (Department) a request for an appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for an appeal concerns the determination of Auto Club Insurance Association (Respondent) that the Petitioner overutilized or otherwise rendered or ordered inappropriate treatment, products, services, or accommodations under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Respondent issued the Petitioner a bill denial on October 5, 2021. The Petitioner now seeks reimbursement in the full amount it billed for the date of service at issue.

The Department accepted the request for an appeal on December 1, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on December 1, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on December 14, 2021. The Department issued a written notice of extension to both parties on January 13, 2021.

The Department assigned an independent review organization (IRO) to analyze issues requiring medical knowledge or expertise relevant to this appeal. The IRO submitted its report and recommendation to the Department on January 4, 2021.

II. FACTUAL BACKGROUND

This appeal concerns the denial of payment for physical therapy treatments rendered on August 12, 2021. The Petitioner billed the treatments under procedure codes 97110 and 97112, which are described as therapeutic exercise and neuromuscular reeducation, respectively.

With its appeal request, the Petitioner's submitted documentation included an *Explanation of Benefits* letter issued by the Respondent, a letter of medical necessity, clinical documentation, and a narrative outlining its reason for appeal. The Petitioner's documentation identified the injured person's diagnoses as other abnormalities of gait and mobility, lack of coordination, generalized muscle weakness,; and diffuse traumatic brain injury (TBI) with loss of consciousness of unspecified duration following a May 1984 motor vehicle accident. In its narrative, the Petitioner noted the injured person's deficits as "abnormal gait with hypertonicity of the right hemi-body, osteoarthritis, and chronic right hip and knee pain." In a re-examination report dated June 17, 2021, the injured person was to complete physical therapy treatments two times per week for 15 weeks.

In its *Explanation of Benefits* letter, the Respondent denied payment on the basis that treatment exceeded "the period of care for either utilization or relatedness." In its reply, the Respondent reaffirmed its initial denial and cited American College of Occupational and Environmental Medicine (ACOEM) practice guidelines and Official Disability Guidelines (ODG) as the basis for its denial. Specifically, the Respondent stated:

> A prior denial of these requests was made as the medical records that were received did not support these requests. Additional medical [records] have been received and reviewed. In accordance with ACOEM and ODG, Traumatic brain Injury, Head Conditions Disorders, 12-56 visits over 8-12 weeks can be recommended. The medical records do not support this request as the [injured person] has received greater than 100 sessions since 1/7/2019… for the motor vehicle injury 5/16/1984. Per the [Petitioner's] subjective documentation "no new complaints." The additional physical therapy exceeds ACOEM and ODG guideline recommendations, opportunity has been given to establish a home exercise program.

III. ANALYSIS

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that the provider overutilized or otherwise rendered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal involves a dispute regarding inappropriate treatment and overutilization.

The Director assigned an IRO to review the case file. In its report, the IRO reviewer concluded that, based on the submitted documentation, medical necessity was supported on the dates of service at issue and the treatment was not overutilized in frequency or duration based on medically accepted standards.

The IRO reviewer is board-certified in physical medicine and rehabilitation. In its report, the IRO reviewer referenced R 500.61(i), which defines "medically accepted standards" as the most appropriate practice guidelines for the treatment provided. These may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, board, and associations. The IRO reviewer relied on American College of Occupational and Environmental Medicine (ACOEM) clinical practice guidelines for its recommendation.

The IRO reviewer explained that the injured person sustained a traumatic brain injury (TBI) following the 1984 motor vehicle accident. The IRO reviewer opined that, according to the ACOEM practice guidelines, the physical therapy treatments not overutilized in frequency or duration. Specifically, the IRO reviewer opined:

> According to the ACOEM, "Physical therapy is recommended for use in the treatment of chronic severe or moderately severe TBI patients with functional physical deficits." The [injured person] continues to have abnormal gait, hypertonicity of the right side, [osteoarthritis (OA)], chronic right hip OA. [The injured person] continues to require assistance and supervision due to safety. Thus, the request is recommended due to these deficits. Therefore, the request is not considered overutilized.

Based on the above, the IRO reviewer recommended that the Director reverse the Respondent's determination that the physical therapy treatments provided to the injured person on August 12, 2021 were not medically necessary in accordance with medically accepted standards, as defined by R 500.61(i).

IV. ORDER

The Director reverses the Respondent's determination dated October 5, 2021.

The Petitioner is entitled to reimbursement in the amount payable under MCL 500.3157 for the treatment on the dates of service discussed herein, and to interest on any overdue payments as set forth in Section 3142 of the Code, MCL 500.3142. R 500.65(6). The Respondent shall, within 21 days of this order, submit proof that it has complied with this order.

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

This is a final decision of an administrative agency. A person aggrieved by this order may seek judicial review in a manner provided under Chapter 6 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.301 to 24.306. MCL 500.244(1); R 500.65(7). A copy of a petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of Research, Rules, and Appeals, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford